Iowa Department of Human Services

Mental Health System Redesign

Children's Disability Workgroup

Discussion Paper # One: Framing a Children's System of Care in Iowa

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I. Introduction

Senate File 525 calls for the development of "a proposal for redesign of publicly funded children's disability services, included but not limited to the needs of children who are placed out-of-state due to the lack of treatment services" within the state. While the legislation offers no specifics on the framework for a system for children with disabilities, there is a clear charge for collaborate by all key child-serving systems in its development, namely: children's mental health, child welfare, Medicaid services, juvenile justice and the education system. Each system is involved in decisions about accessing or authorizing care, the provision of care and the coordination of care whether by design or default and the treatment benefit (or any lack thereof) has a resulting impact on each of the systems in return.

The Workgroup is not directly addressing changes to Psychiatric Medical Institutions for Children (PMIC's) or the plan for transitioning the administration of PMIC services to the Iowa Plan, however it is important that the redesigned align with and support the intent of the legislature to "improve the reimbursement, expected outcomes, and integration of PMIC services to serve the best interests of children…" The expected outcomes include, but are not limited to the following:

- Addressing PMIC lengths of stay by increasing the availability of less intensive levels of care
- Addressing the development of specialized programs to address the needs of children in need of more intensive treatment who are currently underserved
- The provision of navigation, access and care coordination for children and families in need of services from the children's mental health system
- Integrating the children's mental health waiver services under the Medicaid program with other services (as a means) for ensuring availability of choices for community placement
- Developing profiles of the conditions and behaviors that result in a child's involuntary discharge (from in-state treatment) or out-of-state placement
- Evaluating and defining the appropriate array of less intensive services for a child leaving a hospital or PMIC placement

Though directly charged with bringing home children currently placed out of state the Workgroup, in its first meeting, generally expanded the conversation to include the larger constellation of children served in residential treatment, and those in the "pipeline"[1] in residential treatment. It is logical that the Workgroup address the needs of children who are currently in out-of-state treatment AND to give equal attention to those potentially queuing to fill any emptied beds.

II. Identifying System and Service Gaps

Gaps in today's child-serving system are well described in both the State Plan[2] and in numerous reports to the General Assembly.[3] Iowa does not have organized structure or governance of the children's service system at either the state or county level. Central Points of Coordination (CPC's) that serve as the front door to the adult system are not currently designed to serve children and families. "Instead, children and families may get access through screening and intervention by the healthcare or education systems, through Magellan Behavioral Health for Medicaid members, or through child welfare or juvenile justice."

In the first meeting of the Children's Disability Workgroup members further described and discussed gaps and limitations. Some of those discussion points are synthesized below:

Current System Limitation/Gap	Redesign Attributes

• "Kids get what we've got, not what they need"
  ○ Not enough service nuance and variety to give kids, in a tailored way, what they need
• Child systems operate in a generally isolated fashion in areas that include the following:[4]
  ○ Assessing/addressing problem behaviors (The "tools" available within each system to do so are limited/narrow in scope)
  ○ Recommending/determining the need for placement
  ○ Choice of facility/LOC
  ○ Efforts at intersystem referrals/coordination are hard work
• A high-level understanding of who, why, how children are being referred to and served in residential settings is largely unavailable and/or fragmented
  ○ Numbers of children in placement, and numbers of children in the pipeline for placement and why
  ○ Characteristics/specialized needs of the children
	• Services that are accessible, nimble, nuanced, tailored, accessible, coordinated, developmentally appropriate, specialized.
	• Families have real choice
	• Child-serving systems have ready access to a cross-system array of resource, expertise, strategies and tools capitalizing on the strengths and attributes within and among each system
	• Readily accessible (think dashboard) all-systems

[1] This includes children in shelter beds, and children in inpatient psychiatric facilities who are "stabilized" but deemed in need of residential treatment

[2] See Chapter III Iowa's Mental Health and Disability Service System: Strengths and challenges

[3] Available at www.dhs.iowa.gov/partners/reports/legislativereports/legisreports.html

[4] For example, schools rely on Area Education Agencies for testing and completion of IEP's. Judges rely on Juvenile Court Officers to select a facility. CPS caseworkers making MH/ID treatment linkage decisions.

○ Their service history ○ Whether and what alternatives were considered ○ How the treatment being purchased in the facility will result in a successful return to home and community • Insufficient discharge planning when children return home from residential placement ○ No mechanisms/funding to pull people or systems together to form a coordinated plan ○ Schools unequipped to uniquely support a student's successful return to school ○ Burden falls heavily on parent to navigate/reconnect with applicable systems	intelligence related to capacity, demand, clogs, delays, length of stay, care-coordination • Points of coordination/aid in navigation for children and families when children are returning to their home, school and community

III. Framing a Children's System of Care in Iowa

For many years Iowa has envisioned the implementation of local or regional Systems of Care for children and families. As described in Implementation Status Reports to the General Assembly,[5] the Iowa model involves establishing lead agencies to serve as "front door" access points for services. There is a significant literature, experiences in many other states, and a growing body of evidence to support its inclusion as a cornerstone of the children's system redesign.

One of many definitions of Systems of Care is as follows: "an adaptive network of structures, processes, and relationships grounded in system of care values and principles that provides children and youth with serious emotional disturbance and their families with access to and availability of necessary services and supports across administrative and funding jurisdictions."[6]

Systems of Care is not in and of itself a treatment service, but a philosophy and approach for doing business that permeates and frames virtually all decisions (big ones and every day ones) and interactions and is applied at multiple levels including but not limited to:

- Child and Family care coordination
- Provider
- Community
- Governance
- Policy
- Outcomes

[5] Available at www.dhs.iowa.gov/partners/reports/legislativereports/legisreports.html

[6] Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (2007). *System implementation issue brief #1—Lessons from successful systems:System of care definition.* Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

The "Systems of Care" philosophy is values-rich. It is strength's-based and empowering with belief in the resiliency of children and their innate capacity to live fulfilling and meaningful lives. Family voice is infused at every level. Listening to youth and families, who have lived the experience, worked hard at navigating the system and know first-hand the "gap" between what is available and what is needed is an essential part of both redesign and future service delivery. It is clear that services must be culturally relevant and child-focused and family driven. Children belong in their homes and communities, supported by a unique mix of formal, informal and natural resources and services that are meaningful to them. Providers "partner and collaborate with" rather than "decide for" children and families in all aspects of treatment planning and decision making. Systems-level outcomes are the measuring stick of effectiveness in place of service or provider-specific outcomes that may if, judged in an isolated fashion, can give false impressions and confidence about the health and well being of a community's children and their families.

There is no question that for states that have operated under a traditional service delivery model the shift in practice is transformational in nature requiring a rethink of virtually every aspect of children's disability policy, funding, design and delivery as laid out by Sheila Pires in the following chart:

Characteristics of Systems of Care as Systems Reform Initiatives

FROM	TO
Fragmented service delivery	Coordinated service delivery
Categorical programs/funding	Multidisciplinary teams and blended resources
Limited service availability	Comprehensive service array
Reactive, crisis-oriented approach	Focus on prevention/early intervention
Focus on "deep end," restrictive settings	Least restrictive settings
Children out-of-home	Children within families
Centralized authority	Community-based ownership
Creation of "dependency"	Creation of "self-help" and active participation
Child-only focus	Family as focus
Needs/deficits assessments	Strengths-based assessments
Families as "problems"	Families as "partners" and therapeutic allies
Cultural blindness	Cultural competence
Highly professionalized	Coordination with informal and natural supports
Child and family must "fit" services	Individualized/wraparound approach
Input-focused accountability	Outcome/results-oriented accountability
Funding tied to programs	Funding tied to populations

Pires, S. (1996). *Characteristics of systems of care as systems reform initiatives*. Washington, DC: Human Service Collaborative.

IV. Considerations for the Workgroup

Below are brief discussions of some of the criteria or factors to be considered in framing services for children. The discussion represents TAC's experiences in other jurisdictions and in Iowa, but should not be assumed to represent either policy recommendations or the position of DHS. The purpose is to stimulate discussion and to inform the analysis of options.

A. Point of Service or Hub for Care Coordination

This is the envisioned access point for children and families. Responsibilities are expected to include care coordination, service navigation, and facilitation of Wraparound Care Planning (or alternate model) for children and families. In addition, these entities will be responsible for convening stakeholders and improving the coordination within and among child serving systems and will be accountable for achieving defined systems-level results.

States and communities are using an array of models in providing similar services and there is no penultimate way of doing it. Considerations include ease of access, geographic proximity, and using settings where families feel comfortable (least-stigmatizing). Some options to consider:

- Mirroring an existing service array so that the pattern is logical and for families and providers to grasp. In Massachusetts regional "Community Services Agencies" (CSA's) share the same boundaries as Child Protective Services agencies. As regional CPC's for adults are envisioned in Iowa, organizing access points for families within the same geographic region is worth consideration.[7]
- Co-location of staff from multiple systems or service levels. Child-serving systems have largely been operating in a parallel rather than integrated fashion and cross-system knowledge and competence is limited. To gain "all-system" knowledge staff from each need to find regular means of collaborating, learning, problem-solving and consensus-building. The Family and Children's First Council that operates a Systems of Care model in Franklin County, Ohio is staffed by individuals from child protective services, juvenile justice, education, intellectual disabilities and mental health. Co-location with adult CPC's would facilitate knowledge transfer across age spans—particularly important for continuity of services to transition-age youth and young adults and for families that access both child and adult service systems.
- Building upon Iowa's existing expertise is also an important consideration. What entities are best poised right now and can demonstrate experience in coordinating or delivering multi-system, family-driven, community-based care? What entities are

[7] Note that services would not need to be confined to one location within the region. Many systems of care activities occur in the home, school or local community. Additionally, the service entity may have multiple office-based locations within a region.

closest to having competence to do this work at all levels of the organization? Are any of these agencies capable and interested in expansion?

B. Target Population

It is of course, a first priority to bring home children who are in out of state residential treatment settings. What other children might be served by served by the Systems of Care Entities and what level of services or support might they receive? "Wraparound Milwaukee" initially focused its work on court-involved multi-system youth and has steadily expanded its reach. In 2008 the program began to serve children "at risk" of court involvement. Even more recently, Wraparound Milwaukee added a program to serve transition-age youth and young adults. In Massachusetts, "Intensive Care Coordination"[8] available to any Medicaid-eligible recipient younger than 21 who is multi-system involved or multi-system eligible.

In Iowa, there is consideration of a Systems of Care structure that provides front door access for all children, even if the depth of the services provided by the entity itself differs based on the intensity of the need. The following chart is a sample of a front-door service mix that might be offered:

SAMPLE SOC Service Matrix	I & R	Short-term system navigation	Family to Family Support	Diagnostic Assessment and Referral	Provider / System Consultation	Wraparound Care Planning
New to service—single system need	X	x	x			
New to service—multiple system need		x	x	x		
Single system—low risk for placement	x	x	x		x	
Multi-system—low risk for placement	x	x	x		x	
Single System—high risk for placement			x	x	x	x
Multi-system—high risk for placement			x	x	x	x
Uninsured or Underinsured—low risk for placement	x	x	x			
Uninsured or Underinsured—high risk for placement			x	x	x	x

C. Necessary Services and Supports to Prevent Placement

[8] The use of the Wraparound Care Planning model in care coordination is required in Massachusetts

Naturally, the effectiveness of any system of care initiative is maximized by ready accessibility to a range of flexible services and supports that are:

- Developmentally appropriate—from birth through young adulthood
- Culturally relevant
- Highly individualized
- Child and family-driven
- Sensitive to change-readiness
- Inclusive of supports that are natural, informal and formal
- Timely—particularly in the event of a crisis situation
- Provided in the community—often in homes or schools
- Evidence-based
- Outcomes-based

A typical array of mental health services includes a mix of traditional (individual or family therapy) and less traditional (in-home therapies such as MST, peer mentoring, family to family peer support) and a full continuum of crisis services (24/7/365, in-home or community-based, resolution-focused interventions; very brief in or out of home stabilization, caregiver support, crisis planning, rapid access to psychiatric intervention).

For children with intellectual disabilities the START (Systemic, Therapeutic Assessment, Respite and Treatment) program model has shown promise in several states including New Hampshire, North Carolina and Tennessee for adults. Programs for children are underway in Ohio and Connecticut. The focus of START is to promote community tenure through effective crisis planning, early intervention, caregiver support, and community collaboration.

V. Conclusion

As indicated earlier in this document, the envisioned redesign of the children's system is transformational in nature. It requires a shared vision for children and families that must cross systems at state and local levels, permeate all aspects of care provision, and guide both policy and workforce development. By all accounts, it is also essential to achieving the promise that "Iowa's children and youth receive mental health treatment, services, and support where they live, work and learn, so that they can remain with their families and in their communities."